STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. Building B. Wing	12/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laguna Honda Hospital & Rehabilitation Ctr D/P Snf	375 Laguna Honda Blvd. San Francisco, CA 94116

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete accurate assessment for one of three sampled residents (Resident B); when coding on Section H of the Minimum Data Set (a resident assessment tool) did not reflect application of intermittent catheterization. Failure to complete accurate assessments may cause potential harm to residents by not providing needed care and services to maintain their highest level of functioning. Findings: Resident B was admitted on [DATE], with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of Resident B's Minimum Data Set (MDS, a resident assessment tool) dated 4/29/21, indicated, Resident B is cognitively intact. Resident B had impairment on both lower extremities that required two-person extensive assist with toileting. Review of Resident B's physician orders [MEDICAL RECORD OR PHYSICIAN ORDER] . (Please) Do ICP (intermittent catheterization procedure) every(q) 12 hours(hrs) and record the volume of urine until discontinued . During an observation on 7/27/21, at 8:48 AM, in Resident B's room, Registered Nurse (RN 1) performed ICP to Resident B. During an interview on 8/10/21, at 11:21 am with MDS Coordinator (MDSC) and concurrent review of Resident B's MDS, dated [DATE] stated, I missed it and added that she will submit a correction of Resident B's MDS assessment. The MDS, under Section H indicated, Intermittent catheterization was coded No. Review of facility policy and procedure (P&P), Completion of Resident Assessment Instrument /Minimum Data Set (RAI/MDS), dated [DATE] indicated, . Purpose: . To ensure accurate and timely completion of the Resident Assessment Instrument/Minimum Data Set . Background: The RAI/MDS is a tool used to identify resident problems, strengths, weaknesses and preferences and provides information for the development of an individualized plan of care .

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for two of three sampled residents (Resident A and Resident B) when the Activities of Daily Living (ADLs, routine activities which includes but not limited to eating, bathing, dressing, toileting, mobility and transfers) care plan was not individualized. The deficient practice had the potential to result in Resident A and B not receiving the care and services to meet their needs. Findings: 1a. Resident B was admitted on [DATE], with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of Resident B's Minimum Data Set (MDS, an assessment tool) dated 4/29/21, indicated, Resident B is cognitively intact. MDS also indicated, Resident B had impairment on both lower extremities and required two-person extensive assist with toileting (including managing her catheter), one-person extensive assist with bed mobility. During an observation on 7/27/21, at 8:48 AM, in Resident B's room, Registered Nurse (RN) 1 performed intermittent catheterization procedure (ICP) to Resident B. Resident B was positioned supine (lying face upward). Resident B not able to move her lower extremities. RN 1 successfully inserted the catheter on the third attempt. RN 1 stated, normally she would not miss the first attempt. RN 1 further stated, the ICP would have been easier if there was another staff to help lift and reposition Resident B's legs. Review of Resident B's ADL care plan, dated 8/22/19, and concurrent staff interview on 7/27/21, at 9:15 AM, with RN 1, ADL care plan indicated, .Interventions . 7. Provide cueing, supervision and/or appropriate level of assistance to promote ADL's/mobility/safety as needed . RN 1 acknowledged the above findings and stated, Resident B's ADL care plan was not individualized. RN 1 also stated, the ADL care plan did not indicate how much assistance and staff support were needed for each ADL. During an interview on 7/27/21, at 9:20 AM, NM 1 stated all licensed staff are responsible for developing and implementing Resident B's comprehensive care plan. NM 1 acknowledged the above findings and stated, he will conduct an in-service to licensed staff to make the residents' ADL care plan person-centered. 1b. Resident A was admitted on [DATE], with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of Resident A's MDS, dated [DATE] indicated, Resident A is cognitively intact. Resident A had impairment on both lower extremities that required extensive assistance with one to two person-assist with bed mobility, dressing and toileting. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident A's ADL care plan, dated 5/4/21, and concurrent interview on 7/27/21 at 12:15 AM, with Quality Management Nurse (QMN) 1, indicated .Interventions . 7. Provide cueing, supervision and/or appropriate level of assistance to promote ADL's/mobility/safety as needed . QMN 1 acknowledged the above findings and stated, the licensed nurses should develop the ADL care plan interventions specific and person-centered to Resident A. Review of Resident A's Care Area Assessment (CAA) dated 5/13/21, indicated, . CAA on ADL Function is triggered by 'Extensive assistance with Bed mobility, Dressing and toilet use; limited assist with personal hygiene, and supervision with eating. Review of facility P&P, Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC) dated 7/9/19, indicated, Policy . 3. The Resident Care Plan (RCP) shall be person-centered, evaluated during weekly or monthly summaries, when indicated for short term problems, every quarter, and revised as needed to serve as an essential resource for improved resident outcomes . It also indicated, . Procedure . 4. Comprehensive Care Plan . a. LHH [Laguna [NAME] Hospital] shall develop and implement a comprehensive person-centered care plan within seven days of completion of the comprehensive assessment . and . 7. Developing Interventions . b. Interventions are specific, individualized and describes the team member(s) responsible for carrying it out and the frequency for conducting the interventions .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the Intermittent Catheterization Procedure (ICP) provided for one of three sampled residents (B), met professional standards of practice. Failure to follow standards of practice could potentially result in Resident B's negative outcome. Findings: 1. Resident B was admitted on [DATE], with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of Resident B's MDS dated [DATE], indicated, Resident B is cognitively intact. Resident B had impairment on both lower extremities that required two-person extensive assist with toileting. Review of Resident B's physician orders [MEDICAL RECORD OR PHYSICIAN ORDER] . During an observation on 7/27/21, at 8:48 AM, in Resident B's room, RN1 conducted the ICP to Resident B. Resident B was positioned supine. RN1 attempted to bend Resident B's knees but Resident B was not able to move her lower extremities. RN1 opened the sterile catheterization tray. RN1 placed sterile drape under Resident B's perineal area. RN1 did not use a flashlight or ask someone assist to hold a flashlight to visualize the urinary meatus. RN1 was unsuccessful on the first and second attempt. During an interview on 7/27/21, at 9:30 AM, RN 1 stated, normally she would not miss inserting the catheter during ICP. RN1 also stated, she had never used a flashlight during Resident B's ICP. RN 1 added the ICP would have been easier if there was another staff to help her lift and reposition Resident B's legs. Record review of facility document, Foley Catheter Insertion Competency for Licensed Nurses, dated 9/21/20, and concurrent staff interview with Director of Staff Development (DSD)1 and DSD2, the document indicated, . Preparations Prior to Catheterization . Gathers and brings equipment needed for the procedure to the resident's bedside . Urinary Catheter . Flashlight (as needed) . 3. Procedure . A. Position resident as follows: Female: Dorsal recumbent position (on back with knees flexed), instruct resident to relax thighs. Alternate position: Sims' position: side-lying with upper leg flexed at knee and hip . Cover or drape resident with blanket so only perineum and genitals are exposed . Positions light to illuminate perineum or have someone assist in holding flashlight to visualize urinary meatus . B. Preparation of Equipment Needed: . Drape resident's perineum. For females, expose labia . DSD 1 stated, staff should check Resident B's care plan to check what level of assistance is needed for him for toileting including ICP. DSD1 further stated, the licensed nurse should have asked for another nursing staff to assist with repositioning and holding the flashlight for best practice of ICP. DSD2 stated, the nursing staff could also use a support band to help hold the weight of Resident B's legs for repositioning for ICP.